



## Complete Summary

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### GUIDELINE TITLE

Surgical management of hemorrhoids.

### BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract (SSAT). Surgical management of hemorrhoids. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2004. 3 p.

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates the previously issued version: Society for Surgery of the Alimentary Tract. Surgical management of hemorrhoids. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p.

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## SCOPE

### DISEASE/CONDITION(S)

- Internal hemorrhoids
- External hemorrhoids
- Acute complications of internal hemorrhoids (prolapse) and external hemorrhoids (thrombosis)

### GUIDELINE CATEGORY

Diagnosis  
Management

Risk Assessment  
Treatment

### **CLINICAL SPECIALTY**

Family Practice  
Gastroenterology  
Internal Medicine  
Surgery

### **INTENDED USERS**

Physicians

### **GUIDELINE OBJECTIVE(S)**

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs

### **TARGET POPULATION**

Adult patients with enlarged and symptomatic hemorrhoids

### **INTERVENTIONS AND PRACTICES CONSIDERED**

#### **Diagnosis**

1. Assessment of symptoms (e.g., local protrusion, pain, swelling, bleeding)
2. Direct visualization by anoscopy or proctoscopy
3. Flexible sigmoidoscopy

#### **Treatment**

1. Conservative therapy for patients with chronic symptoms: stool bulking and topical therapy with ointments or suppositories
2. Outpatient surgical treatment to relieve symptoms if conservative treatment fails (e.g., infrared coagulation, local injection, rubber banding)
3. Laser or traditional surgical hemorrhoidectomy for symptomatic patients with stage III or IV hemorrhoids
4. Excision of residual hemorrhoidal tissue (i.e., external anal tags) during an office visit following episode of an acute hemorrhoidal thrombosis

### **MAJOR OUTCOMES CONSIDERED**

- Relief of pain, bleeding, local protrusion
- Symptom recurrence

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

**DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

Not stated

**NUMBER OF SOURCE DOCUMENTS**

Not stated

**METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Not stated

**RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

**METHODS USED TO ANALYZE THE EVIDENCE**

Review

**DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not applicable

**METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

**DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

**RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

**COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

#### **Symptoms and Diagnosis**

Symptoms of hemorrhoids include local protrusion and swelling, discomfort related to protruding or swollen masses, and bleeding that may be significant enough to result in anemia. These symptoms are nonspecific, and the presence of hemorrhoids should not be presumed since more severe conditions such as inflammatory bowel disease and cancer can mimic hemorrhoidal symptoms. Patients with severe pain or incarcerated protrusions should be seen promptly.

Diagnosis is established with direct visualization by anoscopy or proctoscopy. All patients with rectal bleeding should have their colon examined to rule out proximal sources of bleeding, even in the presence of enlarged hemorrhoids. Since most sources of bright red bleeding are within the reach of a flexible sigmoidoscope, patients should undergo flexible sigmoidoscopy as well as anoscopy to rule out other causes of bleeding. Intermittent protrusion or occasional bleeding does not require urgent consultation. However, patients with acute symptoms of bleeding, pain, or incarcerated protrusions should be seen promptly.

#### **Treatment**

Initial therapy for chronic symptoms of hemorrhoidal disease should be conservative, including stool bulking and topical therapy with ointments or suppositories. Outpatient surgical treatment is appropriate if conservative treatment fails and the patient desires relief of symptoms. Operative treatment is reserved for symptomatic patients with Stage III or IV hemorrhoids. If the patient has evidence of anemia, full colonic examination is indicated and more aggressive treatment necessary.

In patients with Stage I, II, or III disease, local treatment is appropriate in the form of infrared coagulation, local injection, or rubber banding. Stage I and II diseases are effectively treated by any of these modalities, with resolution of symptoms in at least 90% of patients. Cryotherapy should be avoided because of excessive post-treatment symptoms. Stage III disease is probably best treated by hemorrhoidal banding to remove redundant tissue, but long-term resolution of symptoms is likely in only 70% of these patients. Stage IV disease requires surgical intervention, which is associated with long-term resolution of symptoms in 95% of patients. The term "laser hemorrhoidectomy" refers to excision of hemorrhoidal tissues using a laser rather than standard surgical instruments, but is a surgical procedure nonetheless.

Symptoms may also arise from residual hemorrhoidal tissue after an episode of acute thrombosis of external hemorrhoids. These external anal tags may prevent proper cleansing and can be excised during an office procedure if symptoms warrant.

### **Qualification for Performing Surgery for Hemorrhoids**

The qualifications of a surgeon to perform any operative procedure should be based on education, training, experience, and outcomes. At a minimum, the surgical treatment of hemorrhoids should be carried out by surgeons who are certified or eligible for certification by the American Board of Surgery, the American Board of Colon and Rectal Surgery, the Royal College of Physicians and Surgeons of Canada, or their equivalent.

### **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of supporting evidence is not specifically stated for each recommendation.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Following local treatment, symptoms of local protrusion and bleeding should be eradicated. The risk of recurrent symptoms following local treatment varies with the extent of local disease. Hemorrhoidectomy carries a 5% risk of recurrent symptoms.

### **POTENTIAL HARMS**

- Risks of treatment include bleeding and infection. The risk of bleeding after local therapy is about 1%. The risk of infection after local treatment is

unknown, but is certainly less than 1%. Local pain is a common side effect of local treatment. Pain after banding and injection typically lasts 24 to 36 hours, and continued pain requires medical attention. Excessive pain after treatment is due to sphincter spasm and may render urination difficult. Urinary retention is an occasional symptom of occult sepsis.

- Bleeding and infection are greater risks after open hemorrhoidectomy but occur less than 5% of the time. Pain after open hemorrhoidectomy is significant and generally requires narcotics for relief. The fear of bowel movement because of pain may lead to fecal impaction in a few patients. There may be subtle changes in continence of gas or liquid stool following local treatment or surgery, but they are rarely socially significant. Injury to the anal sphincter muscle is a recognized risk but is extremely rare in experienced hands. Anal incontinence is a rare complication of surgery for hemorrhoidal disease.

### **Subgroups Most Likely to be Harmed**

Comorbid conditions such as diabetes, human immunodeficiency virus (HIV), or heart disease increase the risks of local treatment but do not alter the type of complications.

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

These guidelines have been written by the Patient Care Committee of the Society for Surgery of the Alimentary Tract (SSAT). Their goal is to guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the **range** of acceptable clinical practice and should not be construed as a standard of care. These Guidelines require periodic revision to ensure that clinicians utilize procedures appropriately, but the reader must realize that clinical judgment may justify a course of action outside of the recommendations contained herein.

## **IMPLEMENTATION OF THE GUIDELINE**

### **DESCRIPTION OF IMPLEMENTATION STRATEGY**

An implementation strategy was not provided.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Getting Better  
Living with Illness

**IOM DOMAIN**

Effectiveness

**IDENTIFYING INFORMATION AND AVAILABILITY****BIBLIOGRAPHIC SOURCE(S)**

Society for Surgery of the Alimentary Tract (SSAT). Surgical management of hemorrhoids. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2004. 3 p.

**ADAPTATION**

Not applicable: The guideline was not adapted from another source.

**DATE RELEASED**

1996 (revised 2004 Feb 21)

**GUIDELINE DEVELOPER(S)**

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

**SOURCE(S) OF FUNDING**

Society of Surgery of the Alimentary Tract, Inc.

**GUIDELINE COMMITTEE**

Patient Care Committee

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

Not stated

**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

**GUIDELINE STATUS**

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This guideline updates the previously issued version: Society for Surgery of the Alimentary Tract. Surgical management of hemorrhoids. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p.

**GUIDELINE AVAILABILITY**

Electronic copies: Available from the [Society for Surgery of the Alimentary Tract, Inc. Web site](#).

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-U, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-0461.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This summary was completed by ECRI on March 28, 2000. The information was verified by the guideline developer as of May 30, 2000. This summary was updated by ECRI on September 9, 2004.

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